Michigan Department of Community Health

DRAFT HIPAA 5010A1 EDI Companion Guide for ANSI ASC X12N 276/277 Health Care Claim Status Request and Response

Version Date February 22, 2011

Effective January 1, 2012

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

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Introduction

This document is the property of the Michigan Department of Community Health (MDCH). The information contained in this document is for the use of Trading Partners engaging in electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Payment System (CHAMPS).

This document is intended as a companion to the 005010X212 • 276/277 Health Care Claim Status Request and Response Technical Report 3 (TR3) dated August 2006. This document also includes updates appearing in:

- Errata 005010X212E1 • 276/277 Health Care Claim Status Request and Response dated April 2008
- Errata 005010X212E2 • 276/277 Health Care Claim Status Request and Response dated January 2009

The TR3 documents replace the 4010A1 Implementation Guide and related Addenda. The 5010A1 TR3 and related Errata documents can be downloaded from the Washington Publishing Company web site at http://www.wpc-edi.com/content/view/817/1.

This document is expected to be used in conjunction with the TR3 and related Errata for the 276/277 transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This document provides MDCH-specific instructions regarding certain elements within the TR3 but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDCH rules regarding:

- Identifiers to use when a national standard has not been adopted
- Parameters in the TR3 and related Errata that provide options

In order to successfully download HIPAA transactions from the CHAMPS system it is necessary to comply with the information contained in the MDCH Electronic Submission Manual Dated February 2009. Note that revision of the MDCH Electronic Submission Manual is expected during calendar year 2011. The most current version of this manual can be downloaded from the MDCH web site at the following location: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42545_42638---,00.html.

Transaction Description

The 276 is used to specifically inquire about the status of one or more claim submitted to a payer for adjudication. The 277 is the payer's response to the 276 request. When the submitter's request is processed successfully without errors, the 277 returns status on all claims that meet the criteria supplied in the corresponding 276.

General Notes for 276/277 Health Care Claim Status Request and Response

- 276 Claim Status Inquiry transaction is supported for the following types of claims (invoice type):
  - Professional
  - Institutional (all types)
  - Dental
- The following data elements are used by MDCH as search criteria:
  - Provider NPI
  - Subscriber (Beneficiary) ID
  - Payer's Claim Number (CHAMPS 18-digit Transaction Control Number – TCN)
  - Date of Service
  - Patient Control Number
- The Transaction Control Number (TCN) is optional and, when not included in the request, the submitted date of service or dates of service range will be used in combination with the Provider ID and Subscriber ID to locate the claim(s).
- 276/277 transactions apply for fee-for-service claims submitted to the CHAMPS system. If a 276 Claim Status Request is submitted either for a legacy claim or encounter then a 277 Claim Status Response will be returned with a status "Claim-Encounter not found".
- 276 Health Care Claim Status Request transactions are processed on a daily basis. 277 Health Care Claim Response will be returned within 24-48 hours.
- Header Date of Service (DOS) or Line DOS is required on the 276 Claim Status Request. If the DOS is not submitted, then "Claim not found" will be returned on 277 Claim Status Response.
- When a 276 Claim Status Request is submitted and finds a match on more than one claim, then the 277 Claim Status Response will be returned for all the matched claims based on the claim search criteria described above. If only Header information is

submitted on the 276 Claim Status Request, then 277 Claim Status Response will be returned with both Header and Line information.

- MDCH will return either a positive or a negative 999 Acknowledgement, when a 276 Claim Status Request transaction is accepted or when syntactical errors are encountered.
- Sender ID and Receiver ID submitted at the Interchange (ISA06 and ISA08) or Functional (GS02 and GS03) level must be present in CHAMPS and must be a valid DEG ID, CHAMPS Provider ID, or NPI. If not, the file will be rejected and a negative 999 Acknowledgement will be returned.

This document uses several text conventions to aid in the interpretation of the Companion Guide Rules. The following table lists the text conventions used in this document.

Convention used	Explanation
< >	Text included within < > is the “Implementation Name” field from the TR3 document
“ ”	Text with “ ” around a value represents HIPAA TR3 values.
( )	The HIPAA TR3 description of the value in quotes, described above, is provided parenthetically.

Upload/Submission Notes for ANSI ASC X12 276 Health Care Claim Status Request

Please refer to the MDCH Electronic Submission Manual for information regarding:

- Interaction with the MDCH’s Data Exchange Gateway (DEG)
- Modes of submission (FTP, SSL FTP, HTTPS, or electronic batch submission)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

ANSI ASC X12 276 Health Care Claim Status Request Companion Guide Rules

276 - Interchange Control Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present (No Meaningful Information in I02))
	ISA	ISA02	Authorization Information	10 spaces.
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04))
	ISA	ISA04	Security Information	10 spaces.
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID For FTP, SSL FTP, or HTTPS use the DEG ID left justified, followed by spaces For electronic batch use the CHAMPS Provider ID or NPI, left justified, followed by spaces
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	“D00111" left justified followed by spaces
			Functional Group Header	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID For FTP, SSL FTP, or HTTPS use the DEG ID. For electronic batch use the CHAMPS Provider ID or NPI This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"D00111" for MDCH

276 - Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100A			**Loop - Payer Name**	
2100A	**NM1**		**Segment - Segment - Payer Name**	
2100A	NM1	NM103	Name Last or Organization Name	<Payer Name> “Michigan Department of Community Health” or “MDCH”
2100A	NM1	NM108	Identification Code Qualifier	“PI” (Payer Identification)
2100A	NM1	NM109	Identification Code	<Payer Identifier> “D00111” for MDCH
2100B			**Loop - Information Receiver Name**	
2100B	**NM1**		**Segment - Information Receiver Name**	
2100B	NM1	NM108	Identification Code Qualifier	“46” (Electronic Transmitter Identification Number (ETIN))
2100B	NM1	NM109	Identification Code	<Information Receiver Identification Number> For FTP, SSL FTP, or HTTPS use the DEG ID. For electronic batch use the CHAMPS Provider ID or NPI This value should always match ISA06 <Interchange Sender ID> and GS02 < Application Sender's Code >

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100C			**Loop - Provider Name**	
2100C	**NM1**		**Segment - Provider Name**	
2100C	NM1	NM108	Identification Code Qualifier	"XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2100C	NM1	NM109	Identification Code	<Provider Identifier> 1. Billing Provider NPI should be submitted. 2. Billing Provider NPI should be associated with the Billing Agent and Billing Agent association with MDCH should be active.
2100D			**Loop - Subscriber Name**	
2100D	**NM1**		**Segment - Subscriber Name**	
2100D	NM1	NM108	Identification Code Qualifier	"MI" (Member ID)
2100D	NM1	NM109	Identification Code	<Subscriber Identifier> Report the MDCH beneficiary 10-digit identification number.
2200D			**Loop - Claim Status Tracking Number**	
2200D	**REF**		**Segment - Payer Claim Control Number**	
2200D	REF	REF01	Reference Identification Qualifier	"1K" (Payer Claim Number)
2200D	REF	REF02	Reference Identification	<Payer Claim Control Number> 18-digit CHAMPS TCN
2200D	**REF**		**Segment - Patient Control Number**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2200D	REF	REF01	Reference Identification Qualifier	"EJ" (Patient Account Number)
2200D	REF	REF02	Reference Identification	<Patient Control Number> Patient Control Number may be submitted if it is known and present on the claim for which the status request is being submitted.
2200D	**DTP**		**Segment - Claim Service Date**	
2200D	DTP	DTP03	Date Time Period	<Claim Service Period> 1. From - To Date span cannot be greater than 30 days. 2. Date of service cannot be older than 5 years from the system date. 3. To Date cannot be less than From Date. 4. When there is a 276 status inquiry on suspended claim(s) due to invalid DOS (From/To) then "Claim not Found" will always be returned on 277. 5. Header DOS should always be submitted in the 276 request if Line DOS is not submitted, else "Claim not found" will be returned on the 277 response.
2210D			**Loop - Service Line Information**	
2210D	**DTP**		**Segment - Service Line Date**	
2210D	DTP	DTP03	Date Time Period	<Service Line Date> 1. From - To Date span cannot be greater than 30 days. 2. Date of service cannot be older than 5 years from the system date.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				3. To Date cannot be less than From Date. 4. When there is a 276 status inquiry on suspended claim(s) due to invalid DOS (From/To) then "Claim not Found" will always be returned on 277. 5. Line DOS should always be submitted in the 276 request if Header DOS is not submitted, else "Claim not found" will be returned on 277 the response.

Download/Receipt Notes for ANSI ASC X12 277 Health Care Claim Status Response

Please refer to the MDCH Electronic Submission Manual for information regarding:

- Interaction with the MDCH's Data Exchange Gateway (DEG)
- Modes of retrieval (ASCII and binary formats) including Line Feed information

ANSI ASC X12 277 Health Care Claim Status Response Companion Guide Rules

277 - Interchange Control Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I02)
	ISA	ISA02	Authorization Information	10 spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04)
	ISA	ISA04	Security Information	10 spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	"D00111" left justified followed by spaces.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	Value received on 276 Request ISA06 < Interchange Sender ID >

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				will be returned.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	"D00111"
	GS	GS03	Application Receiver's Code	Value received on 276 Request GS02 <Application Sender's Code> will be returned.

277 - Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	
	ST	ST02	Transaction Set Control Number	<Transaction Set Control Number> MDCH will assign a unique number within the transaction set to indicate the start of the transaction. MDCH will transmit identical transaction set control numbers in ST02 and SE02.
2100A			**Loop - Payer Name**	
2100A	**NM1**		**Segment - Segment - Payer Name**	
2100A	NM1	NM103	Name Last or Organization Name	<Payer Name> "Michigan Department of Community Health" or "MDCH"
2100A	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2100A	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDCH
2100B			**Loop - Information Receiver Name**	
2100B	**NM1**		**Segment - Information Receiver Name**	
2100B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number (ETIN))

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100B	NM1	NM109	Identification Code	<Information Receiver Identification Number> Value received on 276 NM109 (Loop 2100B Information Receiver Name) will be returned.
2200B			**Loop - Information Receiver Trace Identifier**	
2200B	**STC**		**Segment - Information Receiver Status Information**	
2200B	STC	STC01-1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.)
2200B	STC	STC01-2	Industry Code	<Status Code> The following code is returned when the submitted data is invalid: "153" (Entity's ID number)
2200C			**Loop - Provider of Service Trace Identifier**	
2200C	**STC**		**Segment - Provider Status Information**	
2200C	STC	STC01-1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.)
2200C	STC	STC01-2	Industry Code	<Status Code>

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				The following codes are returned as applicable when the submitted data is invalid: "21" (Missing or Invalid Information) "562" (Entity's National Provider Identifier (NPI))
2200D			**Loop - Claim Status Tracking Number**	
2200D	**STC**		**Segment - Claim Level Status Information**	
2200D	STC	STC01 - 1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.) When the submitted data is valid and finds a match based on the claim (s) search criteria, one of the following codes are returned based on CHAMPS Business Status present on claim: Business Status – Paid F1 = Finalized / Payment - The Claim / line has been paid Business Status – Denied F2 = Finalized / Denied - The Claim / line has been denied Business Status – Credit

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				F3 = Finalized/Revised - Adjudication information has been changed Business Status – Suspended P2 = Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, re-pricing, Third Party Administrator processing) Business Status – Adjusted F3 = Finalized/Revised - Adjudication information has been changed Business Status – Inprocess P1 = Pending/In Process-The claim or encounter is in the adjudication system Business Status - Void F4 = Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "D0" (Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.)
2200D	STC	STC01 - 2	Industry Code	<Status Code>

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				The following codes are returned as applicable when the submitted data is invalid: "21" (Missing or Invalid Information) "33" (Subscriber and Subscriber ID not found) "187" (Dates(s) of Service) "464" (Payer Assigned Claim Control Number) When the submitted data is valid and finds a match based on the claim (s) search criteria, the standard status code(s) present on claim(s) are returned as applicable. When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "35" (Claim/encounter not found.)
2220D			**Loop - Service Line Information**	
2220D	**STC**		**Segment - Service Line Status Information**	
2220D	STC	STC01 - 1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				When the submitted data is valid and finds a match based on the claim (s) search criteria, one of the following codes are returned based on CHAMPS Business Status present on claim: Business Status – Paid F1 = Finalized / Payment - The Claim / line has been paid Business Status – Denied F2 = Finalized / Denied - The Claim / line has been denied Business Status – Credit F3 = Finalized/Revised - Adjudication information has been changed Business Status – Suspended P2 = Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, re-pricing, Third Party Administrator processing) Business Status – Adjusted F3 = Finalized/Revised - Adjudication information has been changed Business Status – Inprocess P1 = Pending/In Process-The claim or encounter is in the adjudication system Business Status - Void

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				F4 = Finalized/Adjudication Complete - No payment forthcoming- The claim/encounter has been adjudicated and no further payment is forthcoming When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "D0" (Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.)
2220D	STC	STC01 - 2	Industry Code	<Status Code> The following code is returned when the submitted data is invalid: "188" (Statement from-through dates.) When the submitted data is valid and finds a match based on the claim (s) search criteria, the standard status code(s) present on claim(s) are returned as applicable. When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "35" (Claim/encounter not found.)

Revision Log

Version Date	Effective Date	Revision Description
February 22, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide For The HIPAA 276/277 Health Care Claim Status Request & Response Addenda, Version 4010A1* dated November 17, 2009.